PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, May 24, 2005, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Paul J. Cote, Jr., Commissioner, Department of Public Health, Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Maureen Pompeo, Mr.Albert Sherman, Ms. Janet Slemenda, Mr. Gaylord Thayer, Jr., and Dr. Martin Williams. Dr. Thomas Sterne was absent. Also in attendance was Atty. Donna Levin, General Counsel.

Commissioner Cote, Chair, announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Dr. Susan Gershman, Director, Massachusetts Cancer Registry; Ms. Sally Fogerty, Associate Commissioner, Center for Community Health; Dr. Bruce Cohen, Co-Director, Center for Health Information, Statistics, Research, and Evaluation; Ms. Karen Granoff, Director, Office of Patient Protection; Atty. Carol Balulescu, Deputy General Counsel, Office of the General Counsel; and Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control.

RECORDS:

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Records of the Public Health Council Meetings of March 22, 2005.

PERSONNEL ACTIONS:

In letters dated May 6, 2005, Val W. Slayton, MD, MPP, Chief Medical Officer, Tewksbury Hospital, Tewksbury, recommended approval of appointments and reappointments to the various medical and allied health staffs of Tewksbury Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with the recommendation of the Chief Medical Officer of Tewksbury Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the various medical and allied health staffs of Tewksbury Hospital be approved for the period of May 1, 2005 to May 1, 2007:

APPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Eduardo Talusan, MD	43555	Provisional Consulting Staff Ophthalmology
Carol Widrow, MD	206358	Provisional Active Staff Psychiatry
REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Murat Anamur, MD	72107	Consultant Hematology/Oncology
Seema Arora, MD	154170	Affiliate/Internal Medicine
Charles Carroll, PhD	3060	Allied Psychology

Jesus Flores, MD	41509	Active/Internal Medicine
Michael Popik, MD	52454	Consultant Radiology

In a letter dated May 10, 2005, Blake Molleur, Executive Director, Western Massachusetts Hospital, recommended approval of reappointments to the affiliate and consulting medical staff of Western Massachusetts Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following reappointments to the affiliate and consulting medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Denzil Reid, MD	207874	General Medicine/Pulmonology
L. Willis Roberts, MD	80758	General Surgery

In a letter dated May 9, 2005, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of an appointment and reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointment and reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital be approved:

APPOINTMENT:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
David Rubin, MD	223491	Consultant/Internal Medicine
REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Jonathan Hertz, MD	212535	Consultant/Psychiatry
Timothy Pace, MD	150244	Active/Psychiatry
Marc Homer, MD	35380	Consultant/Radiology
Lisa Kachnic, MD	77022	Radiation Oncology
Christopher Cua, MD	70534	Thoracic Surgery
Janice Rothschild, MD	57559	Consultant/Surgery
John Morgan, DDS	20040	Consultant/Dentistry
Carol Bowen, CNS	130826	Allied Health Professional
Beth Ferguson, PA	62	Allied Health Professional

STAFF PRESENTATION: "CANCER INCIDENCE AND MORTALITY IN MASSACHUSETTS 1998-2002: STATEWIDE REPORT":

Dr. Susan Gershman, Director, Massachusetts Cancer Registry, made a presentation on the Statewide Report, "Cancer Incidence and Mortality in Massachusetts 1998-2002. Some Highlights from the report follow:

- From 1998 to 2002 there were 171,729 newly diagnosed cases of cancer and 69,298 deaths from cancer among Massachusetts residents. The average annual age-adjusted incidence rate was 522.0 per 100,000 persons, and the average annual age-adjusted mortality rate was 205.6 per 100,000 persons. Overall, cancer incidence and mortality rates in Massachusetts stabilized over the years 1998-2002.

- Prostate cancer was the most common type of newly diagnosed cancer among Massachusetts males. Prostate cancer accounted for 30% of new cancers among males in the state from 1998 to 2002. The average annual age-adjusted incidence rate of prostate cancer was 186.2 per 100,000 males. The annual incidence rate of prostate cancer fluctuated over the years without any statistically significant trend from 1998 to 2002.

- From 1998 to 2002, invasive breast cancer was the most common type of newly diagnosed cancer among Massachusetts females, accounting for approximately 31% of new cancers among females in the state. The average annual age-adjusted incidence rate of breast cancer was 144.8 per 100,000 females. The incidence rate of female invasive breast cancer decreased significantly over the years 1998-2002, by 2.5% annually. Breast cancer in situ was included in this report as a separate category. The age-adjusted incidence rate of in situ for Massachusetts females was 47.5 per 100,000. The mortality from breast cancer also decreased during this period by 1.5% annually, though not significantly.

- Cancer of the bronchus and lung was the most common cause of cancer deaths among both Massachusetts males and females between 1998 and 2002, accounting for 29% of all deaths among males and about 25% of all deaths among females. During this time period, the mortality rate of cancer of the bronchus and lung in Massachusetts decreased by 1.6% annually for males and increased by 1.5% annually for females. These changes were not statistically significant.

- For all types of cancer combined for 1998-2002, black, non-Hispanics had the highest age-adjusted incidence and mortality rate among Massachusetts males.

- Between 1998 and 2002, cancers of the prostate, bronchus and lung, and colon/rectum were the top three most commonly diagnosed cancers, and cancer of the bronchus and lung was the most common cause of cancer death for all Massachusetts male race/ethnicity groups.

- For all types of cancer combined for 1998-2002, white, non-Hispanics had the highest age-adjusted incidence rate and black, non-Hispanics had the highest age-adjusted mortality rate among Massachusetts females. Cancers of the breast, bronchus and lung, and

colon/rectum were the top three most commonly diagnosed cancers for all Massachusetts female race/ethnicity categories during this time period. Cancer of the bronchus and lung was the most common cause of cancer death among all female race/ethnicities in Massachusetts.

- The age-adjusted incidence rates in Massachusetts were higher than their national counterparts. The Massachusetts male and female incidence rates from 1998-2002 were 620.0 per 100,000 and 459.0 per 100,000, while the rates for the North American Association of Central Cancer Registries (NAACCR) were 566.1 per 100,000 and 420.0 per 100,000, respectively.

- Similarly, the age-adjusted mortality rates in Massachusetts for males and females were slightly higher than the age-adjusted mortality rates in the United States. For all cancers sites combined, 258.7 per 100,000 versus 258.3 per 100,000 for males and 174.1 per 100,000 versus 173.9 per 100,000 for females.

- The lung cancer incidence and mortality rates have decreased in males over the past decade, but are still increasing in females. However, the annual incidence and mortality rates among females have continued to grow but at a slower rate since the middle of the 90s.

NO VOTE/INFORMATION ONLY

MISCELLANEOUS: REQUEST FOR ADOPTION OF NEW GOVERNING BODY STRUCTURE AND BYLAWS FOR THE PUBLIC HEALTH HOSPITALS:

Chair Cote made remarks regarding adoption of the new governing body structure and bylaws for the public health hospitals. He said, "…At our last meeting this item was on the docket and we tabled it so that there could be additional information provided to the Council Members. I will try to give you some background information and then I will ask you whether or not you would like a staff presentation or whether you feel ready to vote. What has come to our attention is that the actual vehicle for providing governance to the hospitals is too far removed from the actual hospitals themselves so that, if there are operating issues and concerns around the operation of the hospitals, in order to get those issues addressed at a governance level, one actually has to travel fairly far through the organization of the Department to move an issue up, and essentially loses focus. It takes a great deal of time, and actually has to compete in terms of time and interest relative to the Commissioner and the existing, designated governing group. What we tried to do is to move a governing structure down closer to, more immediately accessible to the hospitals so that, when there are issues, they can be raised to a governing board, which can actually make recommendations relative to policy and take action in a more timely fashion. That being said, we believe the changes that are being proposed don't effect, in any way, the role of the Public Health Council, or the Commissioner, relative to the operation of the hospitals. It simply, from my perspective, vastly improves a system of accountability to ensure that critical issues received the attention that they need in a timely fashion…"

A brief discussion followed, Council Member George, Jr. asked about the Department of Mental Health's (DMH) involvement in the new governance structure. Chair Cote said in part, "The Department of Mental Health is a full-fledged member of governance so that they are participating with us to what I call a more representative governance of those facilities (Lemuel Shattuck Hospital and Tewksbury Hospital where the DMH operates inpatient psychiatric units). They are there at the table and are participants." Council Member Thayer, Jr. stated, "I thought that the material that was provided this time was head and shoulders above last time. I appreciate yours and the staff's effort in putting it together, the time you took to talk it through. It is a lot clearer now what is going on."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Request for **Adoption of New Governing Body Structure and Bylaws for the Public Health Hospitals;** and that a copy be attached and made a part of this record as **Exhibit No. 14, 813**.

PROPOSED REGULATION: INFORMATIONAL BRIEFING REGARDING AMENDMENTS TO 105 CMR 128.000: HEALTH INSURANCE CONSUMER PROTECTION:

Ms. Karen Granoff, Director, Office of Patient Protection, accompanied by Atty. Carol Balulescu, Deputy General Counsel, Office of the General Counsel, presented the proposed amendments to 105 CMR 128.000 to the Council. Ms. Granoff said in part, "…I know you have received packets and there were a number of changes we made, some substantive, others just technical. I am not going to spend time on the technical questions, but I do want to spend a little bit of time on the substantive changes that we are proposing, and these come out of the past four and a half years since the office has been in operation. These are based on the experiences we have had in our work with the health plans, and our goal is to make it as fair a process as we can for both the health plans and for the patients. The first thing we are proposing is adding a definition for actively practicing. Actively practicing appears both in the Division of Insurance regulations, as well as in our regulations, under the internal and external appeal process, and what we are trying to do is make it very clear that the clinician who is reviewing the appeal, both internally through the health plan as well as externally through the external review agency, is an actively practicing physician. Because we recognize that there is a lot of variability in how often a physician may practice, we did not want to prescribe a certain number of hours or weeks, or months that someone had to practice and, therefore, we are proposing that actively practicing be defined simply as somebody who regularly practices medicine."

Ms. Granoff continued, "The next change that we are proposing is also adding a definition for same or similar specialty, and again appears hand-in-hand with actively practicing in the regulations, and it requires both on the internal appeal side as well as the external appeal side that a clinician in the same or similar specialty be used to review appeals. What we are proposing is essentially adopting the NCQA definition of same or similar specialty that virtually all of the health plans in Massachusetts already use, with the addition that, where children are involved and when appropriate, a specialist who treats children is used. The next change that we are proposing is to clarify that while a patient is in the hospital and the hospital is appealing on behalf of that patient for additional days of care, that appeal can come to us without a separate authorization from the patient. What we are trying to do is to simplify the whole process. Right now, if an

authorized rep is going to appeal on behalf of the patient, they need to get that patient authorization. The vast majority of our psychiatric appeals are done by the treating physicians in the hospital on behalf of the patient while he or she is still hospitalized. Sometimes, as you can imagine, it is difficult to get authorization and it can delay the whole process. And so, our proposal is to amend our regulation to not require a patient authorization in that situation only. We are also trying to clarify that the Continuation of Coverage provision, which currently is in effect for the external appeal process and allows continuation of coverage, would also apply on the internal appeal process. We are trying to close a loophole that currently would allow a patient to, if you will, game the system by waiting to file an appeal for services that already were approved by the health plan. Because the regulations say that coverage must continue while the appeal is pending, a patient could ostensively get an additional week for coverage during that process by just waiting to file an appeal. It is really a loophole that is not fair to the health plan, and we are trying to close that loophole."

Discussion followed by the Council. Council Member Thayer requested clarification on the proposed phrase, "Patients need to file in a timely manner". Atty. Carol Balulescu interjected, "It is the timeliness of the filing of the appeal after you have been notified by the health plan that services are no longer covered…We would expect members to act in good faith and, at that time, file their appeal rather than going ahead and getting an additional five or ten PT visits, then filing the appeal once all those visits have been completed and requiring the health plan to pay them without any opportunity for the appeal to have been considered…" Ms. Granoff added, "It doesn't take away the patient's right to appeal. They still have the right to appeal. If their services are overturned, they still get those services. And we would certainly look at any extenuating circumstances, which is why we left the language somewhat vague, but it does give us the opportunity, if somebody does wait two months and then says, oh, gee, I am going to file this now and, by the way, I had thirty occupational therapy visits, you have to cover those, to say, why did you wait two months and, if there are no extenuating circumstances, the health plan is not going to have to cover it."

NO VOTE/INFORMATION ONLY

REGULATION: REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 150.000 ET SEQ. REGARDING THE PROVISION OF AUTOMATED EXTERNAL DEFIBRILLATORS:

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, presented the final amendments to 105 CMR 150.000 to the Council. Dr. Dreyer said in part, "I am here to request final promulgation of these amendments to 105 CMR 150.000. These amendments require all nursing homes to have an Automated External Defibrillator. A public hearing was held on February 18, 2005 and comments accepted through February 23, 2005. At the public hearing, there was overall support for this program. It is a small cost of $1,000 to $2,000 dollars for a defibrillator. These regulations do not apply to rest homes. Those regulations will follow next month. Discussion followed regarding the fact that people have to understand that having a defibrillator present doesn't always mean a life can be saved.

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the **Request for Final Promulgation of Amendments to 105 CMR 150.000 et seq. Regarding the Provision of Automated External Defibrillators**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy of the final regulations be attached and made a part of this record as **Exhibit No. 14, 814**. **As approved, 105 CMR 150.002 (I) states:**

No later than November 30, 2005, the administrator of a nursing facility shall acquire an automated external defibrillator and develop policies and procedures for the rendering of automated extended defibrillation in the facility.

(1) All persons certified to provide automated external defibrillation shall

a. successfully complete a course in cardiopulmonary resuscitation and in the use of an automated external defibrillator that meets or exceeds the standards established by the American Heart Association or the American National Red Cross;

b. have evidence that course completion is current and not expired.

(2) For the purposes of this regulation, the facility shall contract with or employ a physician who shall be the automated external defibrillation medical director for the facility.

a. The medical director shall oversee and coordinate the automated external defibrillation activities of the facility including:

i. maintenance and testing of equipment in accordance with manufacturer's guidelines;
ii. certification and training of facility personnel;
iii. periodic performance review of the facility automated external defibrillator activity.

b. The medical director shall integrate the facility automated external defibrillation activity with the local Emergency Medical response system.

The meeting adjourned at 11:05 a.m.

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Paul J. Cote, Jr., Chair

LMH/lmh